

# Patient Information

Please complete the following information for your patient file.

All of your patient file is confidential medical information and will be maintained as per our HIPAA guidelines.

We will never sell any of your information. Please let us know if you need copies of your patient file.

Patient NAME		Today's DATE: _____	
last:	first, MI	is this form?    initial    revised	

Patient ADDRESSES:	street	city	state	zip	PRIMARY PHYSICIAN INFORMATION name:  phone number:  specialty:

Patient PHONE NUMBERS & EMAILS	
*Please indicate preferred contact number	
home:	text? Y / N
cell:	text? Y / N
work:	ext#
email:	

EMERGENCY CONTACT INFORMATION	
name:	
relationship:	
phone number:	
alternate phone number:	

BIRTHDATE:	
AGE:	
GENDER:	
DATE of initial visit:	
marital status:	
occupation:	
company:	

Family (spouse, children, parents & others...)			patient at our clinic?
Name	relationship	age	

Who Referred you and/or How did you hear about our clinic?	
Medical Professional:	
Patient of our clinic:	
Family member:	
Other:	

Have you ever had Acupuncture? Y / N

When: \_\_\_\_\_ By Whom: \_\_\_\_\_

How Many Treatments: 1    2-5    10-20    more? (\_\_\_\_\_ years)

How did it go? Results / Notes:

iowa  
acupuncture  
clinic



8230 Hickman Rd, Suite B  
Clive, Iowa 50325  
515-331-8948  
www.iowaacupuncture.com

Services at Iowa Acupuncture Clinic:	Fed ID# 391885325
Consulting Practitioner:	
_____ Elizabeth Terrell, L.Ac. IA 004 NPI: 1710318852	
_____ William Terrell, L.Ac. IA 005 NPI: 1194156240	
signed: _____	date: ____ / ____ / ____





### *clinic mission:*

The iowa acupuncture clinic operates as a holistic traditional oriental medical clinic, specializing in acupuncture therapies, herbal medicine, lifestyle counseling and holistic health education.

We honor the holistic nature of life and one's health.

The iowa acupuncture clinic seeks to aid its patients in achieving a greater level of health and well-being. We focus on the individual person, educating them according to an ancient holistic style of oriental medicine. Most importantly, the iowa acupuncture clinic seeks to care for the individual needs of each person.

### *clinic history*

The iowa acupuncture clinic was founded in 1997 by Elizabeth and William Terrell, L. Ac, MSOM., who:

1. were educated in Oriental Medicine at the prestigious Southwest Acupuncture College in Santa Fe, New Mexico,
2. possess Master of Science Degrees in Oriental Medicine (Elizabeth MSOM '95, William MSOM '96),
3. maintain Acupuncture Certification through the NCCAOM (dipl. Ac. ); and
4. are Licensed Acupuncturists (L.Ac.) in Iowa.

### *clinic guidelines*

In an effort to provide our clients with the best care, we request that you follow these guidelines:

1. The iowa acupuncture clinic is maintained as a peaceful, quiet healing space.  
Please limit noise and disturbances.
2. If you ever need any urgent attention, please speak as loudly as necessary.
3. We love and honor children as clients and guests. Please ask to wait with your child in our pediatric treatment area. Please leave the space as tidy as you found it.
4. Please place cell phones and other electronics on mute, and limit their use to necessity.
5. We maintain a toxin free environment for our staff and clientele who have environmental sensitivities.  
Please limit your use of cologne and perfume.  
Smoking is not permitted anywhere on our premises.  
If you have any special environmental needs, please let us know.
6. Payment is due upon completion of visit to clinic.  
Prompt payment discounts will be applied to any payments made at time of completion of visit.  
Please inform our staff, prior to treatments, if you will not be paying in full.  
Please ask for a receipt or insurance form for third-party reimbursement.
7. We all are human and make mistakes, please forgive us ours and we will respect yours.
8. The iowa acupuncture clinic is a health education and lifestyle center. We honor all questions.

## ***acupuncture guidelines***

acupuncture is one of our clinic's most popular treatments, it is also it's most unique;  
as such, please observe the following guidelines when receiving treatment:

1. It is best to wear comfortable, loose fitting clothes. During a treatment, we might need to access various parts of your body, usually your arms, legs, abdomen and back. If you are coming from work, we have hangers for your business clothes and we will provide you with a cover during your treatment.
2. Be sure to eat something during the mealtime prior to your visit. It is very important to have nourishment in your system during an acupuncture treatment. Acupuncture utilizes your body's energy much like an exercise session would, and if your blood sugar is low, you will not respond as quickly to the acupuncture treatments. Please ask us for a snack if you need one.
3. Allow plenty of time for your visit. You will need to spend about 1½ to 2 hours at the clinic during your initial visit. This time allows you to complete our initial paperwork, and allows us to ask you many questions, obtain an accurate diagnosis of your condition and give you an acupuncture treatment. Most of your return visits will last about 1 hour to 1½ hours. Please let us know if you require a quicker treatment.
4. The practice of acupuncture is a licensed medical specialty in the State of Iowa. As such, it is regulated by the Iowa Board of Medical Examiners, located at 400 SW 8th Street, Suite C, Des Moines, Iowa 50309-4686, phone: 515-281-5171. The medical board requires us to state the following:

*The practice of acupuncture in Iowa does not authorize a person to practice medicine and surgery in this state, and the services of an acupuncturist must not be regarded as diagnosis and treatment by a person licensed to practice medicine and must not be regarded as medical opinion or advice.*

***All Practitioners are in full compliance with all regulations and rules promulgated by the Iowa Department of Public Health.***

5. Elizabeth and William Terrell, L. Ac., MSOM practice acupuncture according to Traditional Chinese Medical (TCM) Theory. Please ask for your diagnosis and TCM medical references.
6. The iowa acupuncture clinic exclusively uses sterile, disposable, single use acupuncture needles.
7. If you have any questions, or concerns before, during or after your acupuncture, please call our clinic.

### ***services:***

range of prices vary with severity of health conditions treated  
see brochure for definitions of services

### ***TCM acupuncture and herbal medicine clinic***

initial TCM diagnostic visit	\$25
acupuncture treatment	\$80
return consultation	\$10-80
adjunct acupuncture therapies	\$0-25
couples/group acupuncture (per person)	\$65

I have read the above information and my signature endorses my understanding of the conditions.

Print Name \_\_\_\_\_ relationship to patient: \_\_\_\_\_

signature \_\_\_\_\_ date \_\_\_\_\_

Patient BIRTHDATE:		Phone #:	Services at Iowa Acupuncture Clinic: Fed ID# 391885325 Consulting Practitioner: ____ Elizabeth Terrell, L.Ac. IA 004 NPI: 1710318852 ____ William Terrell, L.Ac. IA 005 NPI: 1194156240  signed: _____ date: _____
Patient NAME: last:   first, MI		visit DATE:	

iowa acupuncture clinic		8230 Hickman Road, suite B Clive, Iowa 50325 Cell/text 515-331-8948
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**Patient Name:** \_\_\_\_\_

Patient's Birthdate: \_\_\_\_\_

## Notice of Privacy Practices

This notice, and the accompanying Practices Regarding Disclosure of Patient Health Information, describes how health information about you may be used and disclosed, and how you can get access to your health information. The Notices are posted near the front desk and copies are available to all individuals receiving care.

Please review this information carefully.

**Understanding your health record:** A record is made each time you visit the Iowa Acupuncture Clinic. Your symptoms, the practitioner's judgments, and a plan of treatment are recorded. This record serves as a basis for planning your care and treatment at future visits, and also serves as a means of communication among other health professionals who may contribute to your care. Understanding what information is retained in your record and how that information may be used will assist you to ensure it is accurate and make informed decisions about who, what, when, where, and why others may be allowed access to your health information.

**Understanding your health information rights:** Your health records is the physical property of the Iowa Acupuncture Clinic, but the content is about you, and therefore belongs to you. You have the right to review or obtain a paper copy of your health record, and to request that appropriate amendments be made to your health record.

You have the right to request restrictions on certain uses and disclosures of your information, to authorize disclosure of the record to others, and be given an account of those disclosures. Other than activity that has already occurred, you may revoke any further authorizations to use or disclose your health information. Should we need to contact you, you have the right to request communication by alternate means or to alternate locations.

**Our Responsibilities:** The Iowa Acupuncture Clinic is required to maintain the privacy of your health information and to provide you with this notice of our privacy practices. We're required to follow the terms of this notice and to notify you if we are unable to grant your request to disclose or restrict disclosure of your health information to others. The Clinic reserves the right to change its practices and promises to make a good faith effort to notify you of any changes. Other than for the reasons described in this notice, the Iowa Acupuncture Clinic agrees not to use or disclose your health information without your authorization.

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## TO SHARE HEALTH AND MEDICAL INFORMATION

Patient Name: \_\_\_\_\_

Please list any persons, medical or otherwise, with whom you authorize us to discuss your health and medical condition. Examples include...family members, DOs, MDs, DCs, Nurse Practitioners, Massage Therapists, Psychologists, Counselors, etc.

You can add or remove persons from this list at any time

Person Authorized

Relationship

Phone (if known)

_____	_____	_____
_____	_____	_____
_____	_____	_____

**TO RECEIVE ADDITIONAL INFORMATION OR REPORT A PROBLEM**, you may contact the Iowa Acupuncture Clinic. If you believe your privacy rights have been violated, you have the right to file a complaint with us and/or with the U.S. Secretary of Health and Human Services with no fear of retaliation by this office.

Authorized Signature:

relationship to patient:

Date:

_____	_____	_____
-------	-------	-------

Witness Signature:

Date:

_____	_____
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## ADDITIONAL AUTHORIZATION TO SHARE HEALTH AND MEDICAL INFORMATION

Date	Add/Remove Authorized Person	Relationship	Phone	Authorized Signature
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_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Iowa Acupuncture Clinic Owners & Acupuncturists:

Elizabeth Terrell, L.Ac. MSOM

William Terrell, L.Ac. MSOM

Licensed Acupuncturists

Masters of Science in Oriental Medicine



### Current Health Issues

Please use this form to list and describe any current health issues.

Be as specific as you wish. Ask for additional paper if necessary.

Reverse Side is your SUPERBILL receipt. Please ask for a copy to file with your Insurance Company

Main Health issues you want addressed:		How have issues changed since last visit?	
		Are conditions worsened by work or life environment? Please Explain.	
Have you had any medical testing since last visit? For what condition and what were the results?		Please use the diagram below to show any areas of (P) pain, (N) numbness, (H) heat, (C) cold, (S) swollen, (E) emotion, (A) acne, (R) rash	
Any new or changed medications/supplements?			
Any changes to your exercise or relaxation activities?			
Patient NAME:		visit DATE:	email:
last:	first, MI		phone:

Patient NAME last: _____ first, MI _____		Patient DOB: ____ mm dd yyyy	Insurance Company: _____	visit DATE: _____
Patient ADDRESS street: _____		city: _____ st: _____ zip: _____	policy holder name: _____	policy #: _____
			Terms: Payment due within 10 days of visit date Patient insurance assignment signature on file	

code.mod	PROCEDURES	qty	price	notes
99201.	first visit, minimal			
99202.	first visit, detailed			
99203.	first visit, extensive			
99211.	return visit eval, min			
99212.	return visit eval, detail			
97810	acupuncture			

Procedure Charges: \$

Suggested Discount  
\$

ICD	DIAGNOSIS	notes

Treatment notes:

tbl up  
tbl dwn  
chair  
mobile

code	PRODUCTS	# pills	times / day	# days	Unit size	Unit price	Units	Total Cost	Notes
						x			
						x			
						x			
						x			
						x			
						x			

non-tax products \$ + (taxable products \$ x 1.07 tax = \$ ) = Total Product Charge \$

Product chrg: \$	+	Prior Balance: \$	=	Product sub: \$	-	Credit Check \$ Cash	=	Product Bal Due: \$
Procedure chrg: \$	-	Pmt at time of visit disc: \$	+	Prior Proc Bal: \$	=	Procedure sub:	-	Credit Check \$ Cash
								Procedure Bal Due:
insurance assign? No / Yes & Bill: \$				Total Visit Due \$		Total Paid \$		
Outstanding \$								

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signed: \_\_\_\_\_ date: \_\_\_\_/\_\_\_\_/\_\_\_\_





Is this form?  
\_\_\_ Initial  
or  
\_\_\_ Update

## Patient History

Please complete this two sided form. page 1/2

### Medication / Supplement / Herbal Medicine List

Please complete the following chart by listing all of the prescription medications, dietary supplements and/or herbal medicines that you are currently taking. describe your current health concerns and your medical history. Please be as detailed as you can. Please use extra pages or your own documents.

medicine/supplement/herb	dosage		medical reason / health benefit	dates taking	
	times/day	total mg/day		start	end

### Surgeries / Medical Procedure History

Please use the following chart to list all surgeries, organ removal, cosmetic surgical procedures, or other invasive medical procedures (such as chemo-therapy, radiation, cataract surgery). Please include bone breaks and lacerations if they required extensive medical care. DO NOT INCLUDE HOSPITAL STAYS DUE TO ILLNESS, you will list those on the opposite page.

surgical procedure	dates performed	reasons for procedure	was it successful? what were results?

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Patient NAME: last: first, MI		visit DATE:	

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## Personal Medical, Illness & Hospital History

page 2/2

Illness / Medical diagnosis Birth defect	dates	were you hospitalized? how long?	what was the result? is it still active illness

## Family Medical History

Please list your family history. Add any grandparents, siblings and/or children that have significant medical history.

member	name	alive/dead	age	health / disease history
mother				
father				

List any allergies and the resulting symptoms	

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# Patient Evaluation Checklist

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Please use the following 2 sided checklist to describe your current (within the last 3 months)  
and/or past health issues (please add dates if serious illness).  
Circle any and all symptoms that apply. Do not worry if symptoms seems contrary. Make any notes you wish.

current	past		current	past		current	past	
<b>Systemic</b>			<b>Digestive / Bowel</b>			<b>Heart / Circulation</b>		
<input type="checkbox"/>	<input type="checkbox"/>	hot body	<input type="checkbox"/>	<input type="checkbox"/>	poor appetite	<input type="checkbox"/>	<input type="checkbox"/>	cold hands / feet
		locations:	<input type="checkbox"/>	<input type="checkbox"/>	excessive appetite	<input type="checkbox"/>	<input type="checkbox"/>	dizziness
<input type="checkbox"/>	<input type="checkbox"/>	cold body	<input type="checkbox"/>	<input type="checkbox"/>	pain before / after eating	<input type="checkbox"/>	<input type="checkbox"/>	chest palpitation
		locations:	<input type="checkbox"/>	<input type="checkbox"/>	mouth / teeth / gum pain	<input type="checkbox"/>	<input type="checkbox"/>	chest tightness
<input type="checkbox"/>	<input type="checkbox"/>	overheats /gets cold easily	<input type="checkbox"/>	<input type="checkbox"/>	clear throat constantly	<input type="checkbox"/>	<input type="checkbox"/>	shortness of breath at rest
<input type="checkbox"/>	<input type="checkbox"/>	sweats easily	<input type="checkbox"/>	<input type="checkbox"/>	throat pain / reflux / Acid	<input type="checkbox"/>	<input type="checkbox"/>	short of breath w/ movement
<input type="checkbox"/>	<input type="checkbox"/>	seldom sweats	<input type="checkbox"/>	<input type="checkbox"/>	difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	fatigue: with movement / at rest
<input type="checkbox"/>	<input type="checkbox"/>	sweats on: head / hands / feet	<input type="checkbox"/>	<input type="checkbox"/>	stomach / abdomen pain	<input type="checkbox"/>	<input type="checkbox"/>	erratic pulse
<input type="checkbox"/>	<input type="checkbox"/>	sweat has strong odor	<input type="checkbox"/>	<input type="checkbox"/>	bad breath	<input type="checkbox"/>	<input type="checkbox"/>	fast / slow pulse
<input type="checkbox"/>	<input type="checkbox"/>	red face	<input type="checkbox"/>	<input type="checkbox"/>	dry mouth	<input type="checkbox"/>	<input type="checkbox"/>	high blood pressure (BP)
<input type="checkbox"/>	<input type="checkbox"/>	overweight	<input type="checkbox"/>	<input type="checkbox"/>	belching / hiccups frequently	<input type="checkbox"/>	<input type="checkbox"/>	normal BP w/medication
<input type="checkbox"/>	<input type="checkbox"/>	heavier in belly / middle	<input type="checkbox"/>	<input type="checkbox"/>	taste in mouth (circle any/all)	<input type="checkbox"/>	<input type="checkbox"/>	high BP w/ medication
<input type="checkbox"/>	<input type="checkbox"/>	heavier in hips / legs			bitter metal sour sweet	<input type="checkbox"/>	<input type="checkbox"/>	low blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	underweight	<input type="checkbox"/>	<input type="checkbox"/>	bowels / rectum pain	<b>Immune / Sinus / Allergy</b>		
<input type="checkbox"/>	<input type="checkbox"/>	weight fluctuates easily	<input type="checkbox"/>	<input type="checkbox"/>	flatulence frequently			
<input type="checkbox"/>	<input type="checkbox"/>	swollen face / hands	<input type="checkbox"/>	<input type="checkbox"/>	undigested food in stool			
<input type="checkbox"/>	<input type="checkbox"/>	swollen legs / feet	<input type="checkbox"/>	<input type="checkbox"/>	bowel incontinence			
<input type="checkbox"/>	<input type="checkbox"/>	acne: face / back / chest / belly	<input type="checkbox"/>	<input type="checkbox"/>	painful bowel movements			
<input type="checkbox"/>	<input type="checkbox"/>	face pain	<input type="checkbox"/>	<input type="checkbox"/>	hemorrhoids / bleeding			
<b>Respiratory</b>			freq of BM times per ____ day or ____ week			<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	shortness of breath	typical BM texture (circle any/all):			<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	fatigue / wheezing with exertion	formed diarrhea loose dry			<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	cough (circle any/all)	BM color (circle any/all):			<input type="checkbox"/>		
		dry / wet / barking	dark light yellow green red			<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	difficulty inhaling / exhaling	shape of BM (circle any/all)			<input type="checkbox"/>		
			tube pencil thin pebbles			<input type="checkbox"/>		
			large small other:_____			<input type="checkbox"/>		

## Notes / Extra Details :

Patient BIRTHDATE:		Phone #:	Services at Iowa Acupuncture Clinic: Fed ID# 391885325
Patient NAME:		visit DATE:	Consulting Practitioner:
last:	first, MI		_____ Elizabeth Terrell, L.Ac. IA 004 NPI: 1710318852
			_____ William Terrell, L.Ac. IA 005 NPI: 1194156240
		signed:_____	date:_____

Patient NAME:		visit DATE:
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 signed: \_\_\_\_\_ date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## Patient Evaluation Checklist (...continued from front page)

Please use the following 2 sided checklist to describe your current (within the last 3 months) and/or past health issues (please add dates if serious illness).  
 Circle any and all symptoms that apply. Do not worry if symptoms seems contrary. Make any notes you wish.

current	past	
<b>Energy / Sleep</b>		
energy level?	high mod low	
motivation?:	high mod low	
time to bed?:	regular irregular	
time awake?	rested fatigued	
hours of sleep per day: _____		
<input type="checkbox"/>	<input type="checkbox"/>	erratic energy / fatigue
<input type="checkbox"/>	<input type="checkbox"/>	fatigued easily
<input type="checkbox"/>	<input type="checkbox"/>	weak voice
<input type="checkbox"/>	<input type="checkbox"/>	difficulty falling asleep
<input type="checkbox"/>	<input type="checkbox"/>	wake frequently thru night
<input type="checkbox"/>	<input type="checkbox"/>	to urinate?
<input type="checkbox"/>	<input type="checkbox"/>	to eat?
<input type="checkbox"/>	<input type="checkbox"/>	because of pain?
<input type="checkbox"/>	<input type="checkbox"/>	disturbing dreams / nightmares
<input type="checkbox"/>	<input type="checkbox"/>	vivid dreams
<input type="checkbox"/>	<input type="checkbox"/>	night sweats
<input type="checkbox"/>	<input type="checkbox"/>	hot / cold flashes
<input type="checkbox"/>	<input type="checkbox"/>	daily need for nap

### Urogenital

frequency of urine per day? \_\_\_\_\_  
 frequency of night urine? \_\_\_\_\_  
 typical color & quality of urine:

clear	light	dark	fluorescent
bloody	cloudy	milky	frothy

☐ ☐ painful or burning urination  
☐ ☐ weak stream  
☐ ☐ urgency  
☐ ☐ incontinence / leaking  
☐ ☐ sensation of need without urine  
☐ ☐ low libido  
☐ ☐ pain in groin  
☐ ☐ pain during / after sex  
☐ ☐ headache during / after sex

current	past	
<b>Women's Health</b>		
_____	_____	age of menarche
_____	_____	days in length of monthly cycle
		regular irregular
_____	_____	days of menses flow, describe below
		light medium heavy clots
		painful hemorrhaging
PMS symptoms (circle any/all)? none		
		moody angry breast tender
		sad low back pain cold body
vaginal discharge? none clear		
		white yellow dark blood
_____	_____	age of menopause
_____	_____	age of hysterectomy
		partial or total
<input type="checkbox"/>	<input type="checkbox"/>	prolapse of vagina / bladder
<input type="checkbox"/>	<input type="checkbox"/>	hormone replacement therapy
any other symptoms in women's health?		

### Men's Health

☐ ☐ weak erection  
☐ ☐ painful erection  
☐ ☐ priapism / bent penis  
☐ ☐ inability to orgasm  
☐ ☐ inability to sustain erection  
☐ ☐ prostate pain / swollen  
 any other symptoms?

current	past	
<b>Mental / Emotional</b>		
predominant emotions (check any/all)		
<input type="checkbox"/>	<input type="checkbox"/>	moody
<input type="checkbox"/>	<input type="checkbox"/>	bored
<input type="checkbox"/>	<input type="checkbox"/>	anger/frustration
<input type="checkbox"/>	<input type="checkbox"/>	short temper
<input type="checkbox"/>	<input type="checkbox"/>	joyful
<input type="checkbox"/>	<input type="checkbox"/>	inappropriate laughter
<input type="checkbox"/>	<input type="checkbox"/>	anxious
<input type="checkbox"/>	<input type="checkbox"/>	mania
<input type="checkbox"/>	<input type="checkbox"/>	obsessions
<input type="checkbox"/>	<input type="checkbox"/>	grief
<input type="checkbox"/>	<input type="checkbox"/>	depressed
<input type="checkbox"/>	<input type="checkbox"/>	excessive crying
<input type="checkbox"/>	<input type="checkbox"/>	inability to cry
<input type="checkbox"/>	<input type="checkbox"/>	lack of emotions
<input type="checkbox"/>	<input type="checkbox"/>	disturbed / restless
<input type="checkbox"/>	<input type="checkbox"/>	pain / discomfort due
<input type="checkbox"/>	<input type="checkbox"/>	Seasonal Affective Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Post-Traumatic Stress Disorder
Notes on emotions:		

### Notes/ Extra details:

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